		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0017996

Facility Name: Southgate Health Care Center

Address: 900 East 9th St. (Number) Metropolis (City) 62960 (Zip Code)

County: Massac

Telephone Number: (618) 524-2683 **Fax #** (618) 524-3048

IDPA ID Number: 370993462001

Date of Initial License for Current Owners: 01/01/1964

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 753-3858
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Sam Thompson
(Title) Vice President

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	74	Skilled (SNF)	74	27,084	1
2		Skilled Pediatric (SNF/PED)			2
3	66	Intermediate (ICF)	66	24,156	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,240	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,880	155	3,392	12,427	8
9	SNF/PED					9
10	ICF	22,127	3,735		25,862	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,007	3,890	3,392	38,289	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.72%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/25/1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 2,932

Medicare Intermediary AdminaStar Federal (Louisville, KY)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	155,223	10,245	7,323	172,791		172,791		172,791			1
2	Food Purchase		182,388		182,388		182,388	(1,084)	181,304			2
3	Housekeeping	108,724	16,212		124,936		124,936		124,936			3
4	Laundry	74,238	16,078		90,316		90,316		90,316			4
5	Heat and Other Utilities			72,316	72,316		72,316		72,316			5
6	Maintenance	72,467	13,692	46,729	132,888		132,888		132,888			6
7	Other (specify):*											7
8	**TOTAL General Services**	410,652	238,615	126,368	775,635		775,635	(1,084)	774,551			8
	B. Health Care and Programs											
9	Medical Director			5,200	5,200		5,200		5,200			9
10	Nursing and Medical Records	972,121	139,459	56,075	1,167,655		1,167,655		1,167,655			10
10a	Therapy			317,409	317,409		317,409		317,409			10a
11	Activities	41,165	1,804		42,969		42,969		42,969			11
12	Social Services	48,332			48,332		48,332		48,332			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,061,618	141,263	378,684	1,581,565		1,581,565		1,581,565			16
	C. General Administration											
17	Administrative	242,118			242,118		242,118		242,118			17
18	Directors Fees			4,000	4,000		4,000		4,000			18
19	Professional Services			22,282	22,282		22,282	(1,102)	21,180			19
20	Dues, Fees, Subscriptions & Promotions			32,788	32,788		32,788	(16,753)	16,035			20
21	Clerical & General Office Expenses	112,778	18,650	49,408	180,836		180,836	(600)	180,236			21
22	Employee Benefits & Payroll Taxes			271,411	271,411		271,411		271,411			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,902	15,902		15,902	(7,730)	8,172			24
25	Other Admin. Staff Transportation			17,403	17,403		17,403		17,403			25
26	Insurance-Prop.Liab.Malpractice			167,611	167,611		167,611		167,611			26
27	Other (specify):*											27
28	**TOTAL General Administration**	354,896	18,650	580,805	954,351		954,351	(26,185)	928,166			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,827,166	398,528	1,085,857	3,311,551		3,311,551	(27,269)	3,284,282			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Southgate Health Care Center #0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			138,644	138,644		138,644	(38,666)	99,978			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,064	3,064		3,064	(3,064)				32
33	Real Estate Taxes			20,228	20,228		20,228		20,228			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,927	2,927		2,927		2,927			35
36	Other (specify):*											36
37	**TOTAL Ownership**			164,863	164,863		164,863	(41,730)	123,133			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	167,742	127,032	1,113	295,887		295,887		295,887			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,860	76,860		76,860		76,860			42
43	Other (specify):* Nonallowable Costs			59,123	59,123		59,123	(59,123)				43
44	**TOTAL Special Cost Centers**	167,742	127,032	137,096	431,870		431,870	(59,123)	372,747			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,994,908	525,560	1,387,816	3,908,284		3,908,284	(128,122)	3,780,162			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(600)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(38,666)	30		9
10	Interest and Other Investment Income	(150)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	43		13
14	Non-Care Related Interest	(2,914)	32		14
15	Non-Care Related Owner's Transactions	(1,989)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(4,715)	43		20
21	Owner or Key-Man Insurance	(15,803)	43		21
22	Special Legal Fees & Legal Retainers	(1,102)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,779)	43		24
25	Fund Raising, Advertising and Promotional	(16,453)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,191)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See page 5A	(32,697)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (128,122)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (128,122)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Southgate Health Care Center

ID# 0017996

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending income offset	$ (991)	2	1
2	Marketing expense	(13,894)	43	2
3	PAC contributions	(672)	43	3
4	Out-of-state travel & seminar	(7,730)	24	4
5	Medicare lab expense	(4,811)	43	5
6	Medicare X-ray expense	(4,206)	43	6
7	Dietary rebate	(93)	2	7
8	Chamber of Commerce dues	(300)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(32,697)		49

Southgate Health Care Center
Provider #: 0017996
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Southgate Health Care Center **#** 0017996 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,084)	0	0	0	0	0	0	0	0	0	0	(1,084)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,084)	0	0	0	0	0	0	0	0	0	0	(1,084)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,102)	0	0	0	0	0	0	0	0	0	0	(1,102)	19
20	Fees, Subscriptions & Promotions	(16,753)	0	0	0	0	0	0	0	0	0	0	(16,753)	20
21	Clerical & General Office Expenses	(600)	0	0	0	0	0	0	0	0	0	0	(600)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(7,730)	0	0	0	0	0	0	0	0	0	0	(7,730)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(26,185)	0	0	0	0	0	0	0	0	0	0	(26,185)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,269)	0	0	0	0	0	0	0	0	0	0	(27,269)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Southgate Health Care Center # 0017996 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(38,666)	0	0	0	0	0	0	0	0	0	0	(38,666)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,064)	0	0	0	0	0	0	0	0	0	0	(3,064)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(41,730)	0	0	0	0	0	0	0	0	0	0	(41,730)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(59,123)	0	0	0	0	0	0	0	0	0	0	(59,123)	43
44	**TOTAL Special Cost Centers**	(59,123)	0	0	0	0	0	0	0	0	0	0	(59,123)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(128,122)	0	0	0	0	0	0	0	0	0	0	(128,122)	45

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jane Ann Parker	86.00					
Sam Thompson	4.67					
Jeff Thompson	4.67	N/A		N/A		
Shelly MacCauley	4.66					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V				N/A				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Sam Thompson	Operations	Administrative	4.67	None	40+	66.67	Salary	$ 168,156	17 (1)	1
2	Jeff Thompson	Maintenance	Maintenance	4.67	None	40+	100.00	Salary	28,080	6 (1)	2
3	Mary Lynn Thompson	Accountant	Clerical	0.00	None	40+	100.00	Salary	40,040	21 (1)	3
4											4
5	Sam Thompson	Director	Administrative	4.67	None	40+		Directors Fee	1,000	18(3)	5
6	Jeff Thompson	Director	Administrative	4.67	None	40+		Directors Fee	1,000	18(3)	6
7	Shelly MacCauley	Director	Administrative	4.66	None	< 1	< 2%	Directors Fee	1,000	18(3)	7
8	William T. Parker	Director	Administrative	0.00	None	< 1	< 2%	Directors Fee	1,000	18(3)	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 240,276		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4					N/A					4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	GMAC		X	Vehicle purchase	$1,130.00	10/31/02	$ 40,686	$ 11,302	10/31/05	zero%	$ none	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Community Bank		X	Line of Credit	demand	2/28/03	60,000		2/28/04	varies	84	6
7												7
8												8
9	TOTAL Facility Related				$1,130.00		$ 100,686	$ 11,302			$ 84	9
	B. Non-Facility Related*											
10	See Schedule 9A		X	See Schedule 9A	$2,165.00	Sch 9A	116,268	95,586	Sch 9A	Sch 9A	2,914	10
11	Miscellaneous interest		X								66	11
12								Less: Interest income offset			(150)	12
13								Non-allowable interest			(2,914)	13
14	TOTAL Non-Facility Related				$2,165.00		$ 116,268	$ 95,586			$ (84)	14
15	TOTALS (line 9+line14)						$ 216,954	$ 106,888			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Southgate Health Care Center
Provider #: 0017996
01/01/04 to 12/31/04 **Schedule 9A**

IX. Interest & Real Estate Tax Expense
Line 10 - Other Non-Facility Related Loans

Lender	Related	Purpose of loan	Monthly Payment	Date of Note	Original Note	Balance	Maturity Date	Interest Rate	Interest
Mercedes Credit	No	Vehicle purchase	1,415	02/28/03	76,104	55,422	05/31/08	0.0490	2,914
Chrysler Credit	No	Vehicle purchase	750	12/20/04	40,164	40,164	11/20/09	0.0490	-
			2,165		116,268	95,586		0	2,914

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 18,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 19,464	2
3. Under or (over) accrual (line 2 minus line 1).		$ 764	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 19,464	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 20,228	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	15,768	8
	2000	16,739	9
	2001	17,006	10
	2002	18,755	11
	2003	19,464	12

Accrual = current tax bill

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Southgate Health Care Center COUNTY Massac

FACILITY IDPH LICENSE NUMBER 0017996

CONTACT PERSON REGARDING THIS REPORT SamThompson

TELEPHONE (618) 524-2863 FAX #: (618) 524-3048

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-01-450-001	BK 150	$ 17,371.26	$ 17,371.26
2.		All blk 150 ex triangular portion	$	$
3.		parcel n pt of:	$	$
4.		Addition to Metropolis	$	$
5.	08-01-451-01	BK 151	$ 544.82	$ 544.82
6.		Addition to Metropolis	$	$
7.	08-01-448-002	Bk 148 - W 80 ft except N 26 ft	$ 233.54	$ 233.54
8.		Addition to Metropolis	$	$
9.	08-01-449-001	Bk 149 - All Bld 149 except N 26 ft	$ 1,314.44	$ 1,314.44
10.		Addition to Metropolis	$	$
		TOTALS	$ 19,464.06	$ 19,464.06

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,622 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	185,500	1972	$ 5,000	1
2	Resident Care	193,500	2002	95,000	2
3	TOTALS	379,000		$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1972	1976	$ 207,276	$	30	$ 6,909	$ 6,909	$ 203,816	4
5	37			1976	289,344		30	9,645	9,645	274,883	5
6	10			1989	583,147	18,513	30	19,438	925	300,989	6
7	5			1993	598,429	15,344	30	19,948	4,604	229,402	7
8				1994	13,658	350	30	455	105	4,985	8
	Improvement Type**										
9	Land improvements			1975	7,341		10-30			7,341	9
10	Land improvements			1976	2,886		20			2,886	10
11	Building improvements			1977	1,098		28			1,098	11
12	Land and building improvements			1980	1,014		20			1,014	12
13	Building improvements			1981	57,891		15			57,891	13
14	Land & building improvements			1982	17,279		5-20			17,279	14
15	Building improvements			1983	675		10			675	15
16	Bushes & gravel			1984	888		10			888	16
17	Patio, Med room & improvements			1984	13,078		15			13,078	17
18	Building addition			1984	100,925		20	5	5	100,925	18
19	Gravel road & painting			1985	7,365		3-20			7,365	19
20	Improvements			1985	17,960		15			17,960	20
21	Fire alarm & barn			1985	3,568		20	179	179	3,490	21
22	Improvements			1986	13,163		15			13,163	22
23	Kitchen remodeling			1988	32,477	1,031	30	1,084	53	17,874	23
24	Overhead door/kitchen			1989	852		15	26	26	852	24
25	Flooring			1990	729		10			729	25
26	Fire alarm			1990	9,537	303	20	477	174	6,916	26
27	Dining room improvements			1992	1,824	58	10		(58)	1,824	27
28	Warehouse storage building			1993	17,802	565	30	593	28	7,116	28
29	100 gal lime tank			1995	3,742		15	250	250	2,375	29
30	Drywall resident rooms & bathrooms			1996	2,240	57	10	225	168	1,909	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Parking lot	1997	$ 5,000	$ 299	10	$ 500	$ 201	$ 3,750	37
38	Flooring	1997	674	17	10	68	51	478	38
39	Kitchen plumbing	1997	1,947	50	20	97	47	728	39
40	Tile floor	1997	784	20	10	78	58	585	40
41	Water softener	1997	667	17	10	67	50	502	41
42	Interior design	1997	1,245	32	15	83	51	623	42
43									43
44	Flooring	1998	1,130	29	10	113	84	734	44
45									45
46	Roofing	1999	17,240	442	20	862	420	5,064	46
47									47
48	Roof - Section B	2000	31,346	437	20	1,567	1,130	6,693	48
49									49
50	New laundry building	2001	179,249	4,596	20	8,962	4,366	31,828	50
51	Laundry building flooring	2001	1,219	140	10	121	(19)	425	51
52	Roof replacement	2001	84,500	2,167	20	4,225	2,058	14,788	52
53									53
54	Design & remodel dining room	2002	97,732	2,505	40	2,443	(62)	6,108	54
55	Flooring	2002	39,834	4,878	10	3,683	(1,195)	9,357	55
56	Blinds	2002	2,473	303	10	247	(56)	618	56
57	Awning	2002	996	122	10	100	(22)	250	57
58	Walk in cooler repair	2002	3,361	412	10	336	(76)	840	58
59	Lighting	2002	2,563	314	10	256	(58)	640	59
60									60
61	Flooring	2003	871	149	10	87	(62)	131	61
62	Entryway Carpeting	2003	2,367	406	10	237	(169)	355	62
63									63
64									64
65									65
66									66
67	Flooring	2004	18,000	18,000	10	900	(17,100)	900	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,499,386	$ 71,556		$ 84,266	$ 12,710	$ 1,384,120	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 468,281	$ 6,168	$ 9,613	$ 3,445	5-10	$ 447,798	71
72	Current Year Purchases	2,389	2,389	171	(2,218)	7	171	72
73	Fully Depreciated Assets	190,589					190,589	73
74								74
75	TOTALS	$ 661,259	$ 8,557	$ 9,784	$ 1,227		$ 638,558	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1989 Chevrolet van	1989	$ 18,500	$	$	$	5	$ 18,500	76
77	Resident Care	1983 Ford pickup	1987	4,700				5	4,700	77
78	Resident Care	1999 Dodge Dakota	2000	14,504	1,483	3,626	2,143	5	14,504	78
79	Resident Care	2004 Van	2004	23,024	23,024	2,302	(20,722)	5	2,302	79
80	TOTALS			$ 60,728	$ 24,507	$ 5,928	$ (18,579)		$ 40,006	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,321,373	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 104,620	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 99,978	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,642)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,062,684	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Fully Depreciated Non-Care Assets	$ 76,418	$	$ 76,418	86
87	2005 Jeep Cherokee	40,164	21,086	4,017	87
88	1999 Suburban (2000)	29,810	2,570	28,453	88
89	2001 Envoy (2002)	40,686	5,468	25,888	89
90	2004 Mercedes Benz	76,104	4,900	21,420	90
91	TOTALS	$ 263,182	$ 34,024	$ 156,196	91

G. Construction-in-Progress

	Description	Cost	
92	New facility - Design &	$	92
93	construction. Not yet in		93
94	service	77,416	94
95		$ 77,416	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		N/A		$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,927 Description: Nursing equipment - 160; Dishwasher - 2,767
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	2,735	$ 136,732	$	2,735	$ 136,732	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		399	19,947		399	19,947	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,576	160,550		2,576	160,550	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				102,885		102,885	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(1,2,3)	19492 hrs	167,742	16	954	24,147	19,508	192,843	12
13	Other (specify): See Pg 16A	See 16A			9	339		9	339	13
14	TOTAL			$ 167,742	5,735	$ 318,522	$ 127,032	25,227	$ 613,296	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Southgate Health Care Center
Provider #: 0017996
01/01/04 to 12/31/04 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
VA Physician	39(3)	3	159	
VA Rehab	10A(3)	6	180	
Total to line 13		9	339	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 272,931	$ 272,931	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 41,455)	774,112	774,112	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	73,539	73,539	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	28,117	28,117	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee receivable	529	529	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,149,228	$ 1,149,228	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000	100,000	13
14	Buildings, at Historical Cost	3,381,318	2,499,386	14
15	Leasehold Improvements, at Historical Cost	78,493		15
16	Equipment, at Historical Cost		721,987	16
17	Accumulated Depreciation (book methods)	(2,219,050)	(2,062,684)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See schedule 17A	78,343	78,343	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,419,104	$ 1,337,032	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,568,332	$ 2,486,260	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 136,331	$ 136,331	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	87,390	87,390	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,107	6,107	31
32	Accrued Real Estate Taxes(Sch.IX-B)	19,464	19,464	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	239,170	239,170	36
37	Deferred Income-Resident Liability	87,874	87,874	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 576,336	$ 576,336	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	106,888	106,888	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 106,888	$ 106,888	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 683,224	$ 683,224	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,885,108	$ 1,803,036	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,568,332	$ 2,486,260	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Southgate Health Care Center
Provider #: 0017996
01/01/04 to 12/31/04 **Schedule 17A**

XV. Balance Sheet

Line 23 (Other)

Capitalized license cost	927
Construction in progress	77,416
Total-Line 23	78,343

Line 36 (Other Current Liabilities)

Other Accrued Expenses	8,193
Insurance Premiums Withheld	1,855
Due IDPA-Audit	144,137
Due IDPA-Coinsurance	84,985
Total-Line 26	239,170

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,830,205	1
2	Restatements (describe):		2
3			3
4	**Adjustments subsequent to cost report preparation**	(132,245)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,697,960	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	306,153	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(119,008)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	3	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 187,148	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,885,108	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,317,684	1
2	Discounts and Allowances for all Levels	376,735	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,694,419	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	8,949	5
6	Therapy	333,034	6
7	Oxygen	2,401	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 344,384	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	117,149	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	9,850	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 126,999	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,441	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,441	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See attached Schedule 19A	45,203	28
28a	Vending Income	991	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 46,194	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,214,437	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	775,635	31
32	Health Care	1,581,565	32
33	General Administration	954,351	33
	B. Capital Expense		
34	Ownership	164,863	34
	C. Ancillary Expense		
35	Special Cost Centers	355,010	35
36	Provider Participation Fee	76,860	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,908,284	40
41	**Income before Income Taxes (line 30 minus line 40)****	306,153	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 306,153	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Southgate Health Care Center
Provider #: 0017996
01/01/04 to 12/31/04 **Schedule 19A**

XVII. Income Statement

Prior year billing adjustments	44,785
Other income	418
Total - Line 28	45,203

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 45,428	$ 21.84	1
2	Assistant Director of Nursing	2,473	2,473	47,550	19.23	2
3	Registered Nurses	7,617	7,617	125,420	16.47	3
4	Licensed Practical Nurses	21,467	21,467	278,168	12.96	4
5	Nurse Aides & Orderlies	85,895	85,895	635,891	7.40	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,000	19,737	9.87	9
10	Activity Assistants	2,665	2,665	21,428	8.04	10
11	Social Service Workers	3,975	3,975	48,332	12.16	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,935	12.95	13
14	Head Cook	6,830	6,830	45,220	6.62	14
15	Cook Helpers/Assistants	8,030	8,030	51,270	6.38	15
16	Dishwashers	5,550	5,550	31,798	5.73	16
17	Maintenance Workers	5,753	5,753	72,467	12.60	17
18	Housekeepers	17,913	17,913	116,130	6.48	18
19	Laundry	11,116	11,116	74,238	6.68	19
20	Administrator	2,080	2,080	73,962	35.56	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	168,156	80.84	22
23	Office Manager					23
24	Clerical	9,542	9,542	112,778	11.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	199,146	199,146	$ 1,994,908 *	$ 10.02	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	207	$ 7,323	1(3)	35
36	Medical Director	monthly	5,200	9(3)	36
37	Medical Records Consultant	30	1,505	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	77	1,100	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	314	$ 15,128		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,528	$ 46,051	10(3)	50
51	Licensed Practical Nurses	219	6,578	10(3)	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,747	$ 52,629		53

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle L. Cavitt	Administrator	0.00%	$ 73,962
Sam Thompson	Administrative	4.67%	168,156
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 242,118

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris	Legal	$ 4,406
Denton Kueller	Legal	1,102
American Expr Tax & Bus. Svcs	Accounting	2,935
Altschuler, Melvoin and Glasser	Accounting	7,104
Kemper CPA Group	Accounting	3,460
Williams, Williams & Lentz	Accounting	3,275
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 22,282

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,087
Unemployment Compensation Insurance	12,380
FICA Taxes	147,634
Employee Health Insurance	16,917
Employee Meals	4,189
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	7,696
Employee Recognition & Morale	27,508
TOTAL (agree to Schedule V, line 22, col.8)	$ 271,411

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,000
Advertising: Employee Recruitment	3,033
Health Care Worker Background Check	
(Indicate # of checks performed 92)	1,104
Miscellaneous dues	1,466
Miscellaneous subscriptions	159
Miscellaneous licenses & fees	1,013
Promotional advertising	16,453
IL Health Care Association dues	7,560
Less: Public Relations Expense	(300)
Non-allowable advertising	(16,453)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,035

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedule	15,902
Less: non-allowable expenses	(7,730)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,172

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Southgate Health Care Center
Provider #: 0017996
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	22,282
Non-allowable legal fees:	
Denton Kueller	(1,102)
Total (agree to Schedule V, line 19, column 8)	21,180

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Southgate Health Care Center # 0017996 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $7,560**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **24,229** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **76,860**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **4,189** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	155,223	10,245	7,323	172,791	0	172,791	0	172,791
2. Food Purchase	0	182,388	0	182,388	0	182,388	-1,084	181,304
3. Housekeeping	108,724	16,212	0	124,936	0	124,936	0	124,936
4. Laundry	74,238	16,078	0	90,316	0	90,316	0	90,316
5. Heat and Other Utilities	0	0	72,316	72,316	0	72,316	0	72,316
6. Maintenance	72,467	13,692	46,729	132,888	0	132,888	0	132,888
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	410,652	238,615	126,368	775,635	0	775,635	-1,084	774,551
9. Medical Director	0	0	5,200	5,200	0	5,200	0	5,200
10. Nursing & Medical Records	972,121	139,459	56,075	1,167,655	0	1,167,655	0	1,167,655
10a. Therapy	0	0	317,409	317,409	0	317,409	0	317,409
11. Activities	41,165	1,804	0	42,969	0	42,969	0	42,969
12. Social Services	48,332	0	0	48,332	0	48,332	0	48,332
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,061,618	141,263	378,684	1,581,565	0	1,581,565	0	1,581,565
17. Administrative	242,118	0	0	242,118	0	242,118	0	242,118
18. Directors Fees	0	0	4,000	4,000	0	4,000	0	4,000
19. Professional Services	0	0	22,282	22,282	0	22,282	-1,102	21,180
20. Fees, Subscriptions & Promotion	0	0	32,788	32,788	0	32,788	-16,753	16,035
21. Clerical & General Office	112,778	18,650	49,408	180,836	0	180,836	-600	180,236
22. Employee Benefits & Payroll	0	0	271,411	271,411	0	271,411	0	271,411
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	15,902	15,902	0	15,902	-7,730	8,172
25. Other Admin. Staff Trans	0	0	17,403	17,403	0	17,403	0	17,403
26. Insurance-Prop.Liab.Malpractice	0	0	167,611	167,611	0	167,611	0	167,611
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	354,896	18,650	580,805	954,351	0	954,351	-26,185	928,166
29. Total General Administrative	1,827,166	398,528	1,085,857	3,311,551	0	3,311,551	-27,269	3,284,282
30. Depreciation	0	0	138,644	138,644	0	138,644	-38,666	99,978
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	3,064	3,064	0	3,064	-3,064	0
33. Real Estate	0	0	20,228	20,228	0	20,228	0	20,228
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	2,927	2,927	0	2,927	0	2,927
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	164,863	164,863	0	164,863	-41,730	123,133
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	167,742	127,032	1,113	295,887	0	295,887	0	295,887
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	76,860	76,860	0	76,860	0	76,860
43. Other (specify):*	0	0	59,123	59,123	0	59,123	-59,123	0
44. Total Special Cost Ce	167,742	127,032	137,096	431,870	0	431,870	-59,123	372,747
45. Grand Total	1,994,908	525,560	1,387,816	3,908,284	0	3,908,284	-128,122	3,780,162

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	272,931	272,931
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	774,112	774,112
4. Supply Inventory	0	0
5. Short-Term Investments	73,539	73,539
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	28,117	28,117
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	529	529
10. Total current assets	1,149,228	1,149,228
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	100,000	100,000
14. Buildings, at Historical Cost	3,381,318	3,381,318
15. Leasehold Improvements, Historical Cost	78,493	78,493
16. Equipment, at Historical Cost	0	0
17. Accumulated Depreciation (book methods)	-2,219,050	-2,219,050
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	78,343	78,343
24. Total Long-Term Assets	1,419,104	1,419,104
25. Total Assets	2,568,332	2,568,332
CURRENT LIABILITIES		
26. Accounts Payable	136,331	136,331
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	87,390	87,390
31. Accrued Taxes Payable	6,107	6,107
32. Accrued Real Estate Taxes	19,464	19,464
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	239,170	239,170
37. Other Current Liabilities (specify):	87,874	87,874
38. Total Current Liabilities	576,336	576,336
LONG TERM LIABILITES		
39.Long-Term Notes Payable	106,888	106,888
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	106,888	106,888
46.Total Liabilities	683,224	683,224
47.Total Equity	1,272,802	1,272,802
48.Total Liabilities and Equity	1,956,026	1,956,026

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,317,684
2. Discounts and Allowances for all Levels	376,735
Subtotal - Inpatient Care	3,694,419
4. Day Care	0
5. Other Care for Outpatients	8,949
6. Therapy	333,034
7. Oxygen	2,401
Subtotal - Anciliary Revenue	344,384
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	-
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	117,149
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	9,850
22. Laundry	0
Subtotal - Other Operating Revenue	126,999
24. Contributions	0
25. Interest and Other Investments Income	2,441
Subtotal - Non-Operating Revenue	2,441
27. Other Revenue (specify):	351,356
28. Other Revenue (specify):	991
Subtotal - Other Revenue	352,347
30. Total Revenue	4,520,590
31. General Services	775,635
32. Health Care	1,581,565
33. General Administration	954,351
34. Ownership	164,863
35. Special Cost Centers	355,010
35. Provider Participation Fee	76,860
37. Other	0
40. Total Expenses	3,908,284
41. Income Before Income Taxes	-8,428,874
42. Income Taxes	0
43. Net Income or Loss for the Year	-8,428,874

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